TESTIMONY

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PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

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Good morning, Mr. Chairman. I am Donald Young, M.D., Executive Director of the Prospective Payment Assessment Commission (ProPAC). I am pleased to be here today to discuss improvements to Medicare's risk contracting program. During my testimony, I will refer to several charts. These charts are appended to the end of my written testimony.

In 1985, Medicare implemented the risk contracting program. Under this program, participating health maintenance organizations (HMOs) receive a monthly capitation payment to provide the Medicare benefit package to each beneficiary they enroll. The risk program was created to allow Medicare to enjoy some of the advantages of capitation arrangements, such as predictable spending and savings. Beneficiaries who join risk plans also benefit because many plans provide additional services and have low cost sharing requirements.

On one level, the risk program has been a success because more and more beneficiaries are choosing to receive services under these arrangements. Since 1993, enrollment has increased, on average, 32 percent each year. Today, 4.2 million beneficiaries, or 11 percent of the total Medicare population, have chosen this option for their health care coverage (see Chart 1).

The risk program has yet to be successful, however, in its goal of achieving savings for the Medicare program. Capitated managed care arrangements have the potential to restrain Medicare expenditures because they create incentives to control the number of services furnished, as well as the cost of each unit of service. These arrangements have helped to curb spending in the private sector. To date, however, the risk program has not achieved the savings that the private sector experience suggests is possible. There are several reasons for this, most notably that Medicare payments to plans do not reflect their enrollees' lower-than-average probability of using health care services. Another reason is that the capitation rates are based on the spending experience of beneficiaries in the fee-for-service program, rather than the costs that would be expected under a managed care arrangement.

In H.R. 2491, the Balanced Budget Act of 1995, the Congress passed a number of reforms to improve the payment methodology for managed care plans. The President also has proposed a number of modifications in his recent budget proposal. ProPAC agrees with the Congress and the President on the need to better adjust risk payments and to move away from fee-for-service spending as a basis for setting rates.

In our forthcoming Report and Recommendations to the Congress, the Commission will recommend a number of modifications that it believes are necessary to improve the risk program. We believe that, if adopted, these actions will benefit both the program and its beneficiaries. These recommendations focus on improvements in three areas: risk adjustment, payment amounts, and risk plan information. This morning, I would like to share with you the Commission's views. But first I will briefly summarize the current method for paying risk plans.

THE RISK PAYMENT METHODOLOGY

As you know, Medicare pays risk plans a monthly payment for each Medicare enrollee to cover the program's share of costs for Medicare-covered services. This rate is based on 95 percent of projected fee-for-service Medicare program payments

(the adjusted average per capita cost or AAPCC) in the county in which the enrollee resides. Separate rates are calculated for aged and disabled beneficiaries and for those who are eligible for Medicare because they have end-stage renal disease. The rates are adjusted by five factors to account for variations in enrollees' health care needs. They are the enrollee's age, sex, Medicaid status, institutionalized status, and whether the person has employer-based coverage. As I will discuss in a moment, these adjustments are not adequate to reflect enrollee spending patterns.

The Medicare program recognizes that risk plans are likely to keep their costs below their payments. While plans are permitted to return to the program any payments that exceed their projected costs, they also may use them to provide extra benefits to risk enrollees. Not surprisingly, most plans choose to offer extra benefits in the form of additional services, lower cost-sharing, or coverage of services from out-of-network providers. To further attract Medicare beneficiaries, plans may include even more benefits than they are required to provide.

Almost every risk plan provides some type of extra benefits. In 1996, the vast majority of plans covered routine physicals and eye exams. Half of plans offered some type of pharmaceutical benefit and two-thirds charged no premium for their basic package. A ProPAC analysis estimated that in 1995, the average risk plan provided each enrollee with $43 in extra benefits each month. The amount of extra benefits varied tremendously across the country, however, even after adjusting them to reflect differences in local price levels (see Chart 2). In 1995, a tenth of plans offered extra benefits valued at over $100 per enrollee per month while another 10 percent offered less than $1. As I will describe later in my testimony, the level of extra benefits that risk plans provide is associated with the payment rates in the areas the plans serve. The variation in the value of extra benefits suggests that fee-for-service spending patterns are not good predictors of the costs plans might be expected to incur.

IMPROVING RISK PAYMENTS

Mr. Chairman, as both the Congress and Administration recognize, if managed care is to be a viable option under Medicare, the risk program must be modified. First, the program needs better risk adjustment methods. Second, Medicare must revise the risk payment methodology. Immediate changes would begin to break the link to fee-for-service spending and reduce the variation in payment rates across areas. Over the longer term, Medicare should consider new ways of setting risk payment rates. I would like to briefly address each of these issues.

The Risk Adjustment Method

In concept, the risk program should generate savings for Medicare because the payment rate is 5 percent less than the fee-for-service spending that would be expected for each beneficiary in an area. Instead, however, research has shown that Medicare payments for current risk enrollees are, on average, an estimated 5 to 7 percent greater than if these beneficiaries had remained in the fee-for-service option. Thus, Medicare is losing, rather than saving, money on the risk program.

These overpayments would be reduced, and spending more appropriately

distributed, if payments for enrollees were adjusted to account for their likely use of services. An adequate risk adjustment method would do this. It would reduce risk plan payments relative to fee-for-service spending to reflect the healthier population of risk plans. Further, it would increase payments to plans that serve sicker beneficiaries and reduce them to plans that have healthier enrollees.

Researchers have been evaluating methods that could be used to better target risk payments. Two have been studied. One uses diagnosis information that accounts for prior health service use. The other is based on enrollee reports of their health and functional status, and past and present health conditions. While a risk adjustment method could be designed that would draw on both types of information, diagnosis information alone measures risk about as well as using both methods together. An outlier policy to address unusually costly enrollees would further improve payments to risk plans.

An improved risk adjustment system would reduce overall risk plan payments as well as redistribute funds across plans and areas. Therefore, it may be appropriate to phase in a new system over time. Mr. Chairman, we know, however, that even the best available risk adjustment method will not fully offset efforts by plans that seek out healthier beneficiaries. Therefore, research needs to continue to seek further improvements in risk adjustment methods. This would help to ensure that Medicare payments to risk plans reflect the health care needs of their enrollees. In the meantime, a partial capitation method should be investigated as a means to reduce the effects of risk selection. This approach would pay plans partially on the basis of their enrollees' utilization, which would be lower for plans that had healthier members.

Risk Plan Base Payments

Another fundamental problem with the risk program is its reliance on fee-for-service spending to set risk payment rates. This approach has resulted in wide variations in risk payment rates. This year, for example, risk plan payments are based on rates that vary by as much as $500 per member per month depending upon the county they serve. Even after adjusting for differences in local input prices, per person payment rates can vary by as much as $200 per month across both urban and rural areas (see Chart 3).

In addition, a plan offering services in neighboring counties may receive very different risk payments for enrollees living in those counties. For example, in the Washington, DC area, the 1997 monthly per person rates range from $401 in Fairfax county to $602 in Prince George's county--a 50 percent difference (see Chart 4).

The current degree of payment variation across areas, particularly among plans within the same area, does not seem to be justified. There are areas where payments are such that risk plans can provide extra benefits. At the same time, payment rates may be too low in other areas, discouraging plans from participating in the program.

In our upcoming report, the Commission recommends several changes to the current system that would result in more appropriate payment levels. These include removing special payments associated with teaching and disproportionate share hospitals, accounting for services provided in military and veterans' facilities, and making other changes that would increase minimum payment levels and further

reduce payment variation. I would like to discuss each of these issues in turn.

Removing Special Payments--Part of the variation in risk payment rates relates to Medicare fee-for-service payment policies that may not reflect the way managed care organizations operate. Because of the way they are determined, the capitation rates include special payments to hospitals that have graduate medical education programs or serve a disproportionate share of low-income patients. Risk plans, however, are not required to use these providers, or pass along these extra payments to them. Consequently, the capitation rates in these areas may be higher than risk plans' costs.

The Commission believes teaching and disproportionate share payments should be removed from the calculation of risk payments. In 1995, these special payments represented about 5.3 percent of total Medicare program spending, with wide variation at the county level. Among the 30 counties with the greatest risk enrollment in 1995, teaching and disproportionate share payments ranged from 1 percent of total fee-for-service spending to almost 20 percent.

This change would reduce the rates the most in counties where fee-for-service spending is higher because of these special payments. In most counties, however, the amount of these payments is low so that risk payment rates would change only slightly. The Commission also believes a separate mechanism should be developed to make additional payments to teaching and disproportionate share hospitals for the Medicare risk plan enrollees they treat. This is necessary to preserve Medicare beneficiaries' access to care in these facilities and to continue Medicare's support for the special roles these institutions play in teaching, research, and serving the poor.

Accounting for VA and DoD Services--Another source of variation is due to services received by Medicare beneficiaries in facilities operated by the Departments of Veterans Affairs and Defense that are not accounted for in Medicare's calculation of fee-for-service rates. In those areas where risk enrollees do not use these facilities to the same extent as beneficiaries in the fee-for-service system, risk payments may be too low. In areas with little risk enrollment, these lower rates might discourage risk plan participation. If payment rates were increased in these areas, adjustments might be needed for those risk enrollees that continue to use DoD or VA facilities.

Other Changes--Even with the modifications I have just mentioned, the Commission believes that other changes are necessary to improve capitation payments. In some areas, payment rates may need to be increased to a minimum level to provide adequate payment for the costs of providing Medicare services. This may be especially important in rural areas where sparse populations and less developed health care infrastructures add additional cost requirements for plans. Any increase in payments, however, should be offset either by reducing all payment rates above the minimum level or by lowering the highest rates.

Overall variation in capitation rates could be constrained in several ways. One way would be to blend local amounts with the national average rate, bringing all payments closer to the average.

Updating Risk Payments

In addition to recommending changes to risk plan base payment rates, the

Commission believes that the method for updating payments must be replaced. Currently, risk payments change each year based on the spending experience in the fee-for-service sector. Because spending in many areas is quite variable, there can be profound changes in risk payments from year to year--especially in counties with few beneficiaries. For example, between 1996 and 1997, the payment rates for several counties jumped by 25 percent or more, while other counties experienced payment decreases of 10 percent or more (see Chart 5). Even for relatively large counties, the rates can vary substantially from year to year. Moreover, the problem can be compounded in areas where relatively healthy beneficiaries are choosing to enroll in risk plans. In those areas, risk plan payment increases are based on the higher spending patterns of sicker beneficiaries remaining in the fee-for-service system. Thus, the payment rates may become increasingly out of line with the costs of serving the risk enrollee population.

Mr. Chairman, this method of updating risk payments is flawed on several fronts. First, and perhaps most importantly, the method provides no way for Medicare to share in savings that occur when risk plan costs increase more slowly than the payment rate. Any difference between payments and costs goes towards extra benefits to enrollees. While extra benefits may be useful to attract beneficiaries, Medicare has no means for retaining any of the excess payment.

Second, updating risk plan payments based on changes in fee-for-service spending may not reflect the performance of managed care plans in providing services to risk enrollees. The fee-for-service system is fundamentally different than managed care. Spending growth under fee-for-service is driven in large part by increases in the volume and intensity of services provided, which reflect fee-for-service payment incentives. A capitated system, by contrast, seeks to control the volume of services provided. In addition, unlike the fee-for-service system, risk plans can negotiate lower prices with providers and can sometimes shift patients from more expensive settings to less costly ones.

The current system for updating risk payment rates should be discarded and replaced by a method that is analytically-based. A formula approach similar to one the Commission uses to recommend hospital payment increases should be implemented. Such a framework would consider factors that are likely to affect plan costs, such as inflation and industry productivity improvements. In this way, Medicare could break the link to fee-for-service spending and permit Medicare to share in the savings associated with any increase in efficiency.

Longer Term Changes to Risk Payments

The Commission believes that risk payments should be based on the costs that an efficiently run plan would be expected to incur in providing Medicare-covered services. As you know, however, this level is difficult to determine. While the Commission believes its recommended changes to the current system will improve the risk payment methodology, it also believes Medicare should begin looking at alternative ways for determining capitation rates. Market-based methods such as competitive bidding and third-party negotiations should be explored. These approaches also would break the link to fee-for-service spending and permit Medicare to take

advantage of many of the same forces private sector purchasers have successfully relied on to reduce their health care costs.

RISK PLAN PARTICIPATION AND BENEFICIARY ENROLLMENT

Changes to the risk payment methodology are necessary to ensure the success of the risk program. These changes have the potential to affect HMO participation in the program as well as beneficiary enrollment. Participation and enrollment could rise in areas where payment levels are increased but could fall in areas where rates are reduced. The likely impact of any changes, however, is difficult to quantify because participation and enrollment depend upon a number of factors. The changes we recommend, however, likely would differ little from changes that any prudent purchaser would impose given similar circumstances.

A recent ProPAC analysis found that HMOs are more likely to participate in the risk program in urban areas with higher payment rates. At the same time, however, there are areas with relatively low payment rates where HMOs participate in the risk program and areas where there is minimal participation despite relatively high payment rates. This suggests that characteristics of the market as well as of the HMO itself also play a role in participation decisions. ProPAC analyses indicate that larger and older HMOs are more likely to participate. This may indicate that success in the commercial market is an important factor in an HMO's decision to enter the risk market. The extent of risk plan competition in an area also influences participation decisions; HMOs are less likely to enter a market where they would face a number of competitors.

Consequently, decisions to participate in the risk program involve a complex decisionmaking process, of which payment rates are only one factor. If faced with lower payment rates, participating plans can choose to not renew their contracts, but there are less drastic alternatives that plans might pursue. Plans could lower their costs through tightening administrative spending, accepting lower profits, or negotiating more stringent rates with providers. They also could reduce the level of extra benefits they offer beneficiaries.

Raising payment rates in certain areas would encourage participation, but other factors may limit HMOs' responses. For example, provider shortages and sparse populations may have a greater influence on plan decisions in rural areas. I should point out that participation may increase in all areas if the Congress decides to expand the program to include additional entities, such as provider service organizations. This may be especially relevant in rural areas where providers who already serve Medicare beneficiaries may choose to develop these entities. Again, however, many factors are likely to come into play.

The impact of rate changes on beneficiary participation also is unclear. A primary reason why Medicare beneficiaries join risk plans is because they can receive extra non-Medicare covered services at no additional costs. ProPAC analyses indicate that plans serving areas with higher payment rates tend to provide richer benefit packages (see Chart 6). But like plan participation decisions, the level of extra benefits offered by plans is influenced by other factors as well. For example, plans in more competitive areas tend to provide a higher level of extra benefits than plans that have

little or no risk plan competition.

Limiting payment rates may reduce the level of extra benefits that risk enrollees would receive. Given the relatively generous extra benefits in high payment areas, it is likely that beneficiaries in these areas would still receive some amount of extra benefits, regardless of any payment reductions. In addition, plans may have other incentives, such as competitive pressures, to forego a share of their profits to maintain a competitive benefit package. It also is possible that as more commercial managed care enrollees age into Medicare, they may choose to continue their coverage under a managed care arrangement, regardless of the level of extra benefits.

IMPROVING RISK PLAN INFORMATION

Mr. Chairman, as the risk program continues to expand, it is increasingly important that the program have sufficient information to ensure that risk payments are appropriate and that plans are delivering quality care. In addition, beneficiaries need to have comparative information to make informed choices between competing risk plans, or choosing between the risk option and remaining in fee-for-service.

Currently, discussions about risk plan payments and costs are hindered because there are no data available on the actual costs risk plans incur to provide Medicare services. The only cost data available are from the adjusted community rate (ACR) proposals that plans annually submit to HCFA. These proposals, used to determine the level of extra benefits that risk plans are required to offer, set forth plans' projected costs in providing the Medicare-covered benefit package, including administrative outlays and profit.

The process used to arrive at these projections is indirect. Plans estimate the monthly per enrollee costs needed to provide the Medicare benefit package to their commercial population and then adjust these estimates upward to reflect the higher usage rates of an older, sicker Medicare population. There is no mechanism to learn whether, and to what extent, risk plans' actual Medicare costs are above or below their projections.

These cost projections may be particularly distorted because of the method plans use to calculate their Medicare administrative costs and profit estimate. Risk plans apply the share of their commercial costs that is devoted to administration and profit to their estimated Medicare patient care costs to obtain this estimate. Because Medicare's service-related costs are, on average, about triple those in the private sector, the amount of costs attributable to Medicare administration and profit is also about three times higher. According to ProPAC analyses of 1995 data, plans estimated they would receive, on average, about $20 per month to cover administrative costs and profit associated with each commercial enrollee. Because of the allocation formula, however, these items accounted for about $66 of risk plans' projected Medicare costs per member per month. I should note that these costs do not affect the payment that plans receive, but rather can alter the level of additional benefits that plans may be required to offer beneficiaries.

The Commission recommends that the Secretary require plans to provide information to assess the costs of furnishing services to Medicare enrollees. This information is needed to evaluate the appropriateness of plan payments as well as the

relationship between payments and costs of care. This information could also be used to assess whether plans are returning appropriate amounts of excess payments to beneficiaries through extra benefits. This data collection would not need to be overly burdensome. It could be obtained through a process similar to that of preparing the current ACR proposal.

Information to monitor and assess the quality of care provided by risk plans also is needed. In a managed care environment where there are incentives to provide less rather than more care, concerns about the quality of care are heightened. The Commission supports the Secretary's efforts to evaluate Medicare risk plans through the use of the Health Plan Employer Data and Information Set (HEDIS) and enrollee satisfaction surveys. While this is a good first step, the Commission believes that quality measurement tools should be evaluated continually and modified to improve the evaluation of plan performance.

Finally, as the risk program expands, more and more beneficiaries will have the choice of enrolling in a risk plan, and choosing among risk plans. To date, beneficiaries have not had adequate information for making these choices. Information about the risk option furnished by Medicare has been general and provided only to new beneficiaries or those who request it. This year, HCFA will introduce a number of initiatives to improve the information beneficiaries can use to decide whether to join a risk plan. ProPAC believes that all beneficiaries should receive quality and satisfaction data about risk plans as well as the fee-for-service system. In this way, beneficiaries can make informed decisions about which option is better for them

CONCLUSION

As Medicare managed care continues to expand, the growth in overall Medicare spending will depend increasingly on the performance of the risk program. This program has the potential to restrain Medicare spending, but only if problems with the payment methodology are addressed. Relying on the current risk adjustment methods and fee-for-service spending distorts risk plan payments. Changes that move towards breaking this link would permit Medicare to fulfill its role as a prudent purchaser of quality health care services for its beneficiaries.

This concludes my formal statement, Mr. Chairman. I would be pleased to answer any questions from you or other members of the Subcommittee.